STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING -- B. WING	03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/08/18 Facility Number: 000775 Provider Number: 15G255 AIM Number: 100248960 At this Emergency Preparedness survey, Res Care Community Alternatives Se In was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 8 certified beds. At the time of the survey, the census was 8. Quality Review completed on 03/14/18 - DA The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0026 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8).	E 0026	**E026:** The facility must develop and implement emergency preparedness policies and procedures. **Corrective Action:** ·Program Manager updated the Emergency Preparedness Manual	03/26/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This deficient practice could affect all occupants. Findings include: Based on review of the Res Care Emergency Disaster Preparedness Manual dated 07/21/17 with direct support professional #1 on 03/08/18 at 1:50 p.m., there was no documentation of the facility role under a declared waiver with Section 1135 in the event of care and treatment at an alternate care site identified by emergency management officials. This was confirmed by direct support professional #1 at the time of record review.		to include applying for the 1135 Waiver for this location in case of an emergency or disaster that would require us to relocate to a facility outside of the Indiana. (**Attachment A**) ·Program Manager will update the Emergency plans annually and as needed. **How we will identify others:** ·In the event of a disaster declared by the President the Program Manager will apply for the 1135 Waiver. ·Program Manager will follow up with CMS to ensure all information has been provided to obtain approval for the waiver in the event we have had to apply. ·Program Manager will update the emergency manual annually and as needed. **Measures to be put in place:** ·Program Manager updated the Emergency Preparedness Manual to include applying for the 1135 Waiver for this location in case of an emergency or disaster that would require us to relocate to a facility outside of the Indiana. ·Program Manager will update the Emergency plans annually and as needed. ·Program Manager will follow up with CMS to ensure all information has been provided to obtain approval for the waiver in the event we have had to apply.	

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			·Annual Mock Drills will be run to ensure all staff are trained and aware of the emergency plans and procedures during a disaster. **Monitoring of Corrective Action:** ·The Program Manager will follow up with CMS to ensure approval is obtained for the 1135 Waiver in the event of a disaster requiring evacuation out of state. ·Emergency Preparedness Plans are updated monthly and as needed to ensure the most accurate information in the event of an emergency. ·Annual Mock Drills are run yearly to ensure all staff are trained and aware of the emergency plans and procedures during a disaster. **Completion Date: 3-26-18**	
E 0031 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term	E 0031	**E031:** The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be updated at least annually.	03/26/2018

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	Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all occupants. Findings include: Based on review of the Res Care Emergency Disaster Preparedness Manual dated 07/21/17 with direct support professional #1 on 03/08/18 at 1:55 p.m., the emergency communication plan contact list lacked contacting the federal, state and regional emergency preparedness staff, the state licensing agency through the gateway link, and the Indiana Bureau of Development Disability Services. This was confirmed by direct support professional #1 at the time of record review.		**Corrective Action:** ·Program Manager updated the emergency contact list to include Federal, State, tribal, Regional and local emergency preparedness staff. (**Attachment B**) ·Program Manager updates Emergency plans are updated monthly to ensure the most accurate contact information is included. **How we will identify others:** ·Program Manager updated the emergency contact list to include Federal, State, tribal, Regional and local emergency preparedness staff. ·Program Manager updates Emergency plans monthly to ensure the most accurate contact information is included monthly and as needed. **Measures to be put in place:** ·Program Manager updated the emergency contact list to include Federal, State, tribal, Regional and local emergency preparedness staff. ·Program Manager updates Emergency plans monthly and as needed to ensure the most accurate contact information is included. ·All staff are trained on the emergency preparedness plans as they are updated or changed.	

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			Monitoring of Corrective Action: ·Program Manager updated the emergency contact list to include Federal, State, tribal, Regional and local emergency preparedness staff. ·Program Manager updates emergency preparedness manual monthly and as needed. ·Area Supervisor trains all staff on the Emergency Preparedness plan and submits training to the Program Manager and HR. **Completion Date: 3-26-18**	
K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/08/18 Facility Number: 000775 Provider Number: 15G255 AIM Number: 100248960 At this Life Safety Code survey, Res Care Community Alternatives Se In was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.	K 0000		

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	15G255	A. BUILDING 02 B. WING	03/08/2018

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	This one story facility with a crawl space was fully sprinkled. This facility has a fire alarm system with smoke detection in the corridors, common living areas, and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.94. Quality Review completed on 03/14/18 - DA			
K S100 Bldg. 02	NFPA 101 General Requirements - Other General Requirements – Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 3 of 3 battery operated emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient	K S100	**K0100:** The facility failed to ensure 2 of 2 fire extinguishers located in the facility were subject to maintenance at intervals of not more than one year. The facility failed to ensure 2 of 2 battery operated emergency lights were maintained. **Corrective Action:** ·Program Manager contacted Simplex Grinnell to have the emergency lights	03/26/2018

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	practice could affect all clients in the facility. Findings include: Based on observation on 03/08/18 with direct support professional #1 during a tour of the facility from 1:25 p.m. to 2:25 p.m., the facility had a battery operated emergency light fixture located on the wall in the dining room, the staff office, and the client sleeping room corridor. Furthermore, when asked if the facility had documentation of monthly testing conducted over the past year, direct support professional #1 stated the facility does not have documentation of monthly testing over the past year or annual ninety minute testing for the three battery backup lights. This was confirmed by direct support professional #1 at the time of observations and interview.		checked/inspected. ·Program Manager will follow up with Simplex Grinnell to ensure completion of the inspection on the 2 of 2 emergency lights located in the facility. **How we will identify others:** ·Area Supervisor completes weekly check, during week 2 the fire extinguishers and emergency lights will be checked to ensure they have been inspected**.** **(Attachment C)** ·Program Manager will follow up with Simplex to ensure completion and Emergency Light inspections. **Measures to be put in place:** ·Area Supervisor will complete weekly check to ensure the fire extinguishers and emergency lights have been inspected and notify the Program Manager. ·Program Manager will contact Simplex Grinnell for any issues with the inspections of the fire extinguishers and emergency lights. **Monitoring of Corrective Action:** ·Program Manager will ensure the Area Supervisor has completed the weekly check to inspect the fire extinguishers and emergency lights. ·Program Manager will contact	

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			Simplex Grinnell for all issues with the fire extinguishers and emergency lights at the facility. ·ResCare Administration will conduct monthly sight reviews to ensure all fire extinguishers and emergency lights are inspected and operable. (**Attachment D**) **Completion Date: 3-26-18**	
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System – Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One– and Two–Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly			

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	(NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____			

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	(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems was tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff. Findings include: Based on record review with direct support professional #1 on 03/08/18 at 1:45 p.m., there was no quarterly sprinkler system inspection conducted for the first quarter or second quarter of the year 2017. Furthermore, the only documentation provided for review by direct support professional #1 at the time of record review was a quarterly sprinkler inspection report from Simplex/Grinnell dated 12/18/17 and 09/27/17. This was confirmed by direct support professional #1 at the time of record review. 2. Based on observation and interview, the	K S353	**K0353: Sprinkler System-Maintenance and Testing** **Corrective Action:** ·Program Manager/ Rescare will ensure all quarterly inspections are scheduled quarterly, annually and as needed. ·Area Supervisor will send the Program Manager all inspection reports upon completion. ·If Simplex has not completed the inspections they will be notified by the Program Manager to ensure the inspection is scheduled and completed. **How we will identify others:** ·Simplex Grinnell services all of Rescares sprinkler and fire alarm needs and completes our quarterly and annual inspections. ·Area Supervisor will submit all Simplex paperwork to the Program Manager for review and to ensure completion. **Measures to be put in place:** ·The Site Supervisor will report any fire or sprinkler system issues to the Area Supervisor. ·The Area Supervisor will contact the Program Manager to report all fire or sprinkler system	03/26/2018

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	facility failed to ensure 2 of 39 sprinklers in the facility which were corroded were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect all clients in the facility. Findings include: Based on observations on 03/08/18 during a tour of the facility with direct support professional #1 from 1:25 p.m. to 2:25 p.m., the outside front porch sprinkler and the front entrance foyer sprinkler were both completely covered in brown corrosion. This was confirmed by direct support professional #1 at the time of observations.		issues at the facility. ·The Program Manager will contact Simplex Grinnell for all service, repairs and scheduling of routine maintenance ·Area Supervisor will submit all Simplex paperwork to the Program Manager for review and to ensure completion. **Monitoring of Corrective Action:** ·Program Manager/ Rescare will ensure all quarterly inspections are scheduled quarterly, annually and as needed. ·Area Supervisor will send the Program Manager all inspection reports upon completion. ·If Simplex has not completed the inspections they will be notified by the Program Manager to ensure the inspection is scheduled and completed. ·The Program Manager will follow up on all service requests that are sent to Simplex Grinnell to ensure completion of the service. **Completion Date: 3-26-18**	